

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

66-0022119

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 1971

DO NOT WRITE  
ON THIS STUB

AMENDED

FILED JUN 3 1966

|                                                                                                                                                                                                                                                                                                                                        |                                                                                                           |                                                                                                                                                             |                                                                                                                                                                      |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>St Louis</u>                                                                                                                                                                                                                                                                                         |                                                                                                           | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MO</u> b. COUNTY <u>St Louis</u>                       |                                                                                                                                                                      |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>Richmond Heights</u>                                                                                                                                                                                                                                           |                                                                                                           | c. CITY OR TOWN <u>Richmond Heights</u>                                                                                                                     |                                                                                                                                                                      |
| Length of stay in 1b <u>6 months</u>                                                                                                                                                                                                                                                                                                   |                                                                                                           | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                                                           |                                                                                                                                                                      |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>6348 Clayton Rd</u>                                                                                                                                                                                                                                  |                                                                                                           | d. STREET ADDRESS (If outside, give location)<br><u>6348 Clayton Rd</u>                                                                                     |                                                                                                                                                                      |
| 3. NAME OF DECEASED (Type or print)<br>First <u>FRANKLIN</u> Middle <u>E.</u> Last <u>BONNEY</u>                                                                                                                                                                                                                                       |                                                                                                           | 4. DATE OF DEATH<br>Month <u>MAY</u> Day <u>28</u> Year <u>1966</u>                                                                                         |                                                                                                                                                                      |
| 5. SEX<br><u>MALE</u>                                                                                                                                                                                                                                                                                                                  | 6. COLOR OR RACE<br><u>White</u>                                                                          | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>9/7/1879</u>                                                                                                                                  |
| 9. AGE (last birthday)<br><u>86</u>                                                                                                                                                                                                                                                                                                    |                                                                                                           | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>FARMER</u>                                                 |                                                                                                                                                                      |
| 11. BIRTHPLACE (City and state or country)<br><u>OAK Ridge, MO</u>                                                                                                                                                                                                                                                                     |                                                                                                           | 12. CITIZEN OF WHAT COUNTRY<br><u>U.S.A.</u>                                                                                                                |                                                                                                                                                                      |
| 13a. FATHER'S NAME<br><u>FRANK BONNEY</u>                                                                                                                                                                                                                                                                                              |                                                                                                           | 13b. MOTHER'S MAIDEN NAME<br><u>LAURA COLLIER</u>                                                                                                           |                                                                                                                                                                      |
| 14. NAME OF HUSBAND OR WIFE<br><u>ALISE BONNEY (DECEASED)</u>                                                                                                                                                                                                                                                                          |                                                                                                           | Address <u>Richmond Heights MO.</u>                                                                                                                         |                                                                                                                                                                      |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, for unknown) <u>NO</u>                                                                                                                                                                                                                                                        |                                                                                                           | 16. SOCIAL SECURITY NO.<br><u>495-54-949X</u>                                                                                                               |                                                                                                                                                                      |
| 17. INFORMANT<br><u>Mrs CLARENCE HEGER</u>                                                                                                                                                                                                                                                                                             |                                                                                                           | Address <u>Richmond Heights MO.</u>                                                                                                                         |                                                                                                                                                                      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>arteriosclerotic Heart Disease</u><br>DUE TO (b) <u>and Myocardial infarction</u><br>DUE TO (c) _____<br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. |                                                                                                           |                                                                                                                                                             | INTERVAL BETWEEN ONSET AND DEATH<br><u>1 year</u>                                                                                                                    |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)                                                                                                                                                                                                      |                                                                                                           |                                                                                                                                                             | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                                                      | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)                                                                |                                                                                                                                                                      |
| 20c. TIME OF INJURY<br>Hour _____ a.m. _____ p.m.<br>Month, Day, Year _____                                                                                                                                                                                                                                                            | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>    |                                                                                                                                                             |                                                                                                                                                                      |
| 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                                                                                                                                                                               |                                                                                                           | 20f. CITY, TOWN, OR LOCATION<br>COUNTY _____ STATE _____                                                                                                    |                                                                                                                                                                      |
| 21. I attended the deceased from <u>5-21-66</u> to <u>5-28-66</u> and last saw him alive on <u>5-27-66</u><br>Death occurred at <u>2:00 AM</u> = <u>5-28-66</u> on the date stated above, and to the best of my knowledge, from the causes stated.                                                                                     |                                                                                                           |                                                                                                                                                             |                                                                                                                                                                      |
| 22a. SIGNATURE (Degree or title)<br><u>Dorothy Bailey M.D.</u>                                                                                                                                                                                                                                                                         |                                                                                                           | 22b. ADDRESS<br><u>6356 Clayton Rd St Louis 17, Mo</u>                                                                                                      |                                                                                                                                                                      |
| 22c. DATE SIGNED<br><u>5-28-66</u>                                                                                                                                                                                                                                                                                                     |                                                                                                           |                                                                                                                                                             |                                                                                                                                                                      |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>                                                                                                                                                                                                                                                                             | 23b. DATE<br><u>MAY 31, 1966</u>                                                                          | 23c. NAME OF CEMETERY OR CREMATORY<br><u>MEMORIAL PARK</u>                                                                                                  |                                                                                                                                                                      |
| 23d. LOCATION (City, town, or county)<br><u>CAPE GIRARDEAU, MO</u>                                                                                                                                                                                                                                                                     |                                                                                                           | (State) _____                                                                                                                                               |                                                                                                                                                                      |
| 24. FUNERAL DIRECTOR<br><u>J.N. Baudouin - Jackson, MO</u>                                                                                                                                                                                                                                                                             |                                                                                                           | 25. DATE RECD. BY LOCAL REG.<br><u>5-29-1966</u>                                                                                                            |                                                                                                                                                                      |
| 26. REGISTRAR'S SIGNATURE<br><u>J. E. Murphy M.D.</u>                                                                                                                                                                                                                                                                                  |                                                                                                           |                                                                                                                                                             |                                                                                                                                                                      |

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK

OR

TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DATE AMENDED

VS 300  
Rev. 4/59

1 4005

2 4005

3

4 0

5 2

6

7 0

8 1

9 420.1

10

11

12 90-0

13

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Gene C. Croust

Licensed Embalmer No. 4327

P. O. Address Jackson, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.